Traditional therapeutics, biomedicine and maternal health in Madagascar: paradoxes and power issues around the knowledge and practices of reninjaza

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Abstract

Public health development in Madagascar is not free from contradictory power dynamics surrounding medical knowledge, and often occurring between biomedicine and traditional healing. In the following paper, we will mainly focus on the therapeutic fields of maternal health, with mortality rates remaining a key public health issue in sub-Saharan Africa. We will examine the paradoxes, power struggles and contradictions affecting medical care during pregnancy and childbirth, with regard to specific knowledge and practices of particular traditional healers: *reninjaza.* The following study will show that institutional, social and political distinctions that fragment medical knowledge into mirroring areas, i.e. "traditional" and "modern" practices, feed power dynamics that obscure social realities at stake in maternal healthcare.

Keywords: Madagascar, traditional midwives, medical traditionalism, biomedicine, maternal health, politics.

Introduction

To face up to the failings of preventive medicine and the deficiencies of hospital care, national and international policies gave a more prominent role to populations in Southern countries to solve their health issues in the late 1970s. These new strategies supported the notion of endogenous development based on existing local capacities (Dozon, 1987). Following the 1978 Alma-Ata Conference, the World Health Organisation recommendations included the actors of traditional medicine in primary healthcare programs. Many countries, especially in sub-Saharan Africa, redefined their health policies to combine biomedicine and traditional therapeutics, and therefore strengthened the construction of their national identity. Humanitarian

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aid networks also contributed to promoting traditional medicine as they were committed to moving towards alternative notions of development (ibid.). The NGOs' programs were thus in line with sceptical and critical movements emerging from Northern countries that challenged over-medicalisation. Recognising alternative medicines to biomedical science thus became a transnational political, social and economic issue.

In Southern countries, however, the challenge of combining biomedical and traditional knowledge fuelled power struggles among practitioners, as well as the continuous redefinition of professional identities and the role of the various actors labelled as "traditional doctors", "traditional practitioners", "folk healers", etc. The specificity of what is referred to as "traditional medicine" lies in its constant state of (re)definition. Power issues and conflicts surrounding medical knowledge which divide the health arena in developing countries brought about multiscale interactions, reinforced by the absence of any real definition of traditional medicine – except in a stereotypical and essentialised opposition to Western modernity (Dozon, 1987). These different changes were also grafted onto postcolonial identity politics that went beyond the scope of medicine. Nonetheless, professionals associated with the biomedical system continued to rule in the health arena and remained in charge of evaluating the capacities and skills of traditional healers. The legitimacy, career paths and socioprofessional recognition of these practitioners, along with the potential combination of their practices to those of biomedical health facilities, therefore continue to be constantly questioned and challenged in an increasingly complex way due to the globalised nature of these debates (Pordié & Simon, 2013).

Public health development in Madagascar is not free from contradictory power dynamics surrounding medical knowledge, which in many fields occur between biomedicine and traditional therapeutics[5] (Lefèvre, 2008; Didier, 2012). We will mainly focus on the field of maternal mortality, which remains one of the key public health issues in sub-Saharan Africa. The majority of women's deaths occur during the third term of pregnancy, during childbirth and immediately after delivery: they are mainly due to haemorrhage, hypertension, infections and obstructed labour (Fournier & Perrault, 2013). In the late 1990s, faced with the high maternal mortality rate, the Ministry of Public Health of Madagascar promoted, with the support of UN agencies and several NGOs, the involvement of traditional practitioners and *reninjaza*[6] in the biomedical maternal health system and developed, among other things, training courses for them. However, the mortality rate only dropped slightly[7]. To the national and international institutions involved, this result was a crucial argument to assert the failings of including traditional healers in the maternal healthcare system and to stop these training courses from 2007. The situation in

[5] In Madagascar, traditional medicine is defined institutionally as the "whole body of knowledge and practices used for diagnosis, prevention and elimination of physical, mental and social imbalances, and based exclusively on practical experience and observations handed down from generation to generation, either orally or in writing, which are used to prevent and cure diseases, and alleviate suffering." (Public Health Code, Bill no. 2011-002).

[6] The term literally means "mother of the child" and can be translated as "traditional midwife" ["matrone", in French], even though some men also carry out this position that is supposed to be for women only. More generally, the word *reninjaza* refers to traditional practitioners who provide healthcare during pregnancy, and during and after childbirth. This is the most commonly used term locally, whereas political and institutional texts use "traditional birth attendant".

[7] The maternal mortality rate per 100,000 live births in Madagascar was 660 for the 1986-1992 period, 469 during the 1998-2000 period, and 498 during the 2002-2009 period. In 2009, the rate of stillbirths was estimated at 21 per 1000 live births (WHO, 2013).

Madagascar is by no means unique: from the 1990s onward, several other sub-Saharan countries stopped offering training courses for "traditional birth attendants" (Fournier & Perrault, 2013).

New directions in aid and development policies were therefore promoted in maternal healthcare. However, the fact that biomedical and traditional practices had existed alongside for several years impacted and shaped the Malagasy health arena in a significant way. It must be noted that the political importance of medical traditionalism in Madagascar goes back to the 1960s, a decade during which research on pharmacopoeia and inventories of medicinal plants and essential oils for therapeutic use flourished (Debray, 1975). Even before the WHO recommendations, several French research organisations such as the Institut Pasteur in Madagascar or the ORSTOM (now the Institut de Recherche pour le Développement), alongside national institutions, took interest in the complex flora of Madagascar and its specific geological history as compared to the rest of the African continent (Cortadellas et al., 2010). From the very beginning, biomedical scientists from Madagascar and abroad were fascinated by the prevalence of endemic species on the island. The knowledge surrounding traditional uses of local plants was also associated with a broader identity politics: the WHO recommendations coincided with the formation of the Second Republic (1975), which promoted a national identity based on a wide process of linguistic "Malagasisation" and a visible trend towards "ancestral heritage" (Rakotomalala, 2002). As was the case in other sub-Saharan countries advocating a socialist regime (Dozon, 1987), promoting Malagasy traditional medicine was a means of revitalising specific values within a broader nation-building political project. The Second Republic constituted a more marked postcolonial break with the Western world, especially France, and supported the development of an authentic Malagasy identity based on primitivism (Amselle, 2010, 2012).

As for therapeutics, traditional healers now enjoy great prestige among populations. Patients' trajectories within the healthcare system show that these tradipractitioners are the first port of call (Pourette et al., 2013). However, as in other Southern countries, this often correlates with the patients' socio-economic backgrounds: if at all possible, they tend to seek out multiple therapies or take both traditional and biomedical remedies (Dozon, 1987; Olivier de Sardan, 1995). On the other hand, some traditional practitioners appear to have an influential status locally, especially among decision makers in rural areas (Ramanantenasoa, 1996) but also in urban settings. As with other healthcare actors, many traditional practitioners' activities stand at the crossroads of the fields of medicine, politics, economics and religion (Fassin, 1992). Their practice falls into several categories, as some are not only consulted for healthcare purposes, but also for their psychic abilities or knowledge of sorcery (Rakotomalala, 2012). Once again, these two skills strongly correlate with positions of social power.

In the present paper, we will focus on the paradoxes and power struggles impacting on maternal healthcare with regard to the specific knowledge and practices of particular traditional healers: *reninjaza*. These female actors in the modern Malagasy "childbirth system"[8] are seldom mentioned: their occupation is regulated by the Public Health Code[9] and is mainly carried out by

[8] Concept used to define childbirth as a biological, social and symbolic event (Jordan, 1978). Moreover, "it defines all actors, practices and perceptions mobilised around this event in a specific healthcare system (be it popular, traditional or biomedical)." (Hancart Petitet, 2011: 11).

[9] Article 96 of Bill no. 2011-002 provides that the word *reninjaza* refers to "any person deemed fit to provide healthcare to women and their newborn babies before, during and after childbirth on the basis of prevalent concepts in her community."

women, although there are a few male *reninjaza*, especially in the capital. *Reninjaza* occupy a unique place in the health arena: they play a key role and attend most deliveries, especially in rural communities, but also in urban areas (Ravololomanga, 1993). *Reninjaza* are therefore well recognised locally. However, they do not enjoy any medical, economic, religious or political prestige. Unlike in other Southern countries, they are not organised in associations either (Boyer, 2006). As a result, their practices are not very highly valued by healthcare authorities and professionals, who accuse them, among other things, of indirectly contributing to the high maternal mortality rate. This lack of regard is not specific to Madagascar: similar views can be found elsewhere concerning the practices of "traditional midwives" (Hancart-Petitet, 2013).
We will nevertheless examine the contradictions and social issues that are developing at several levels around the role and status of *reninjaza*, which are strongly and commonly downplayed from a medical, economic and political perspective. Many of the contradictions within the organisation of the Malagasy maternal healthcare system complicate access to medical treatment for women during pregnancy and childbirth, along with relevant policies.

Our data was collected during several field works focusing on access to healthcare during pregnancy. Several exploratory missions and qualitative studies[10] were conducted in 2012 and 2013 with healthcare professionals, families, *reninjaza* and traditional practitioners in two regions in Madagascar, in rural and urban areas (in the central region of Analamanga and the Vatovavy-Fitovinany region on the east coast). Semi-directive interviews were carried out with 60 women, 30 men, 45 *reninjaza*, 24 health workers and 9 representatives of health authorities, all in the rural and urban areas of Moramanga, Manakara and Antananarivo.

I. Social classes, medical power and the recognition of the role of *reninjaza*

The local social status held by *reninjaza* is primarily due to the fact that they facilitate so many deliveries, especially in rural areas. According to the latest Demographic and Health Study conducted in Madagascar (INSTAT, 2010), one in two women (77% in some regions) give birth with the help of a *reninjaza* (52% in rural areas and 16% in urban areas). But these figures are most likely higher. Moreover *reninjaza* are involved at several points in time during maternity. Before falling pregnant, some women may consult them for reasons of infertility, in which case they are administered massages and herbal teas such as *tambavy*, which is very well known on other islands in the Indian Ocean, especially in the Mascarene Islands (Pourchez, 2011). During early pregnancy, pregnant women use the services of *reninjaza* to confirm that they are expecting. Then, during the course of pregnancy, *reninjaza* administer massages to relieve lower back pains or to try to change the foetus's position, especially just before childbirth. Finally, they attend the delivery, mostly at their patients' homes in rural areas, at their surgery or patients' home in urban areas. They assist women throughout childbirth and after the delivery, as *reninjaza*

[10] These field works were carried out as part of a programme entitled "Risks and social challenges of reproduction in Madagascar" headed by the Institute of Research for Development and led by D. Pourette; of the project entitled "Patrimonialisation of knowledge and practices of traditional birth attendants in Madagascar" funded by the Institute of Research for Development (Regional Pilot Programme on Heritage, Resources and Governance); and of the project entitled "Determinants of use or non-use of antenatal and birthing health facilities in Moramanga" funded by the Institut Pasteur in Madagascar and led by P. Piola and D. Pourette.

also take care of newborn babies and look after the mothers' health[11] daily for about a week after childbirth.

As in many countries where the "childbirth system" comprises traditional midwives or traditional birth attendants (Akoto et al., 2001; Pourchez, 2011), *reninjaza* assert that their knowledge and know-how were passed down to them by their mother, or sometimes their grandmother or their aunt, who carried out the same role within their community. This means that they mainly gained this knowledge and these practices by accompanying members of their family and watching them at work. Some of them also mention an ancestral heritage and a "gift from God", which is interpreted as a blessing given to them as "chosen ones". As in other countries, *reninjaza* usually already have children themselves when they attend their first delivery (ibid.). Their skills are thus based on a non-theoretical body of knowledge and know-how, and are clearly in line with the political and institutional distinction drawn between biomedicine and medical traditionalism. Finally, they often start practising at the request of relatives or neighbours, when their mother, grandmother or aunt can no longer carry out this role or are not on hand to do so. Socially and locally, they are recognised for mastering skills that no one else can practise. This situation creates a social identity that *reninjaza* adopt over the course of their life history and medical practice, as they must comply with social demand.

The local and social status held by *reninjaza* is therefore based on the specific role they play within a population, by whom they are also valued for their fundamentally different attitudes to those of health workers. The behaviour of the latter often reflects the classic asymmetry around medical knowledge that exists between patients and practitioners, but also class dynamics that are especially at play with low-income pregnant women from rural and urban areas. Conflicting relationships between carers and patients, and the latter's misgivings regarding health facilities, are not specific to Madagascar or to the field of maternal health (Jaffré & Olivier de Sardan, 2003). However, in this case, they encourage the use of *reninjaza* by pregnant women for care and treatments. In poorer rural and urban areas, *reninjaza* belong to the same low-income classes and to the same social circles as the pregnant and parturient women they attend to. They are neighbours or family members who sometimes have attended all births in the family. They are popular for being available at all times, for listening to pregnant women's needs, and for showing respect for the moment of childbirth while finding reassuring and comforting attitudes and words. The qualities associated with *reninjaza* are deemed to be lacking in health workers in biomedical infrastructures. Like the women they attend to, *reninjaza* have a limited level of education and therefore do not speak French. This also restricts their recognition among biomedical practitioners and contributes to keeping them at the lower end of the social and medical hierarchy. However, most *reninjaza* can write down the names of the parturient women and their children in Malagasy along with their birth dates in a notebook, which is helpful for recording births. *Reninjaza* play a key role in geographic and social situations where pregnant and poorly educated women cannot be treated in distant or expensive health facilities. By consulting *reninjaza*, they can also avoid the process of social prejudice they are subjected to when encountering health workers.

[11] For example, *sovoka* refers to cold air penetrating into the woman following childbirth, which can be fatal. To prevent *sovoka*, the mother must observe a rest period and stay warm for several weeks or as much as 3 months depending on the region. *Reninjaza* administer specific herbal teas during this period called *mifana*.

However, in these same social contexts, *reninjaza* owe most of their livelihood to agriculture or basket-making – depending on the region – and not to their healthcare practice. This observation can be made in many other Southern countries, especially in rural areas (Akoto et al., 2001). *Reninjaza* do not earn a living from their occupation, as pregnant women and their families either pay them in kind or can only offer small amounts (500 – 5000 ariary). In many cases, too, they do not receive anything for their services. Yet most *reninjaza* we met hope to see their social status rewarded by financial compensations from families or grants from local authorities (e.g. donations in medical supplies such as alcohol, bandages, blades, candles, etc.). They stress they are under pressure within their social networks to monitor pregnancies and attend deliveries as they otherwise would endanger the lives of pregnant women and their children. *Reninjaza* sometimes see this responsibility as a constraint, because they cannot refuse to practise. But it also makes them realise what a key role they play and the social prestige they could enjoy, as with any other actor in the healthcare system.

The fact that there is no correlation between the constant calls upon *reninjaza* to practise and their ordinary social status within their communities is often due not only to a low socio-economic background but also to their position at the lower end of the internal hierarchy of traditional medicine. Their practice is not at the crossroads of economic, religious, political and medical issues, which is what generally confers social prestige to healthcare actors, be they from biomedical or traditionalist spheres. For example, the protection of unborn children from misfortune and death during pregnancy is locally assigned to traditional practitioners. Despite the local status of reninjaza, the central role they play in the "childbirth system", and the fact that they are closest to pregnant women, their knowledge is not on a par with that of traditional practitioners. In the field of maternal health, the most respected sociopolitical power and medical identity associated with traditional knowledge are held by the healers who are only indirect parties to childbirth and whose practices generally relate to other medical issues. By extension, these paradoxes strengthen the distinction and hierarchy between various categories of actors in the medical field. They especially contribute to impeding any broader legitimacy or status for *reninjaza*. Health workers systematically devalue their remedies, for example, which they do not do with traditional practitioners.

The undermining of the status of *reninjaza* in political and medical spheres is particularly notable in Antananarivo, a city in which the intrinsic paradoxes of traditional medicine appear to be multiplied. The knowledge and practices of *reninjaza* are only valued if they are associated with the prestigious status of a traditional practitioner. This is how *reninjaza* in the capital (men and women) can build their social, political and medical legitimacy while strengthening hierarchies within traditional medicine. Some healers from the middle-income and wealthy classes decide to become *reninjaza* and call themselves "traditional birth attendants". However, they attend to far fewer women during pregnancy and childbirth than their counterparts from low-income backgrounds who offer their services to the lowest social classes. These traditional birth attendants are educated men and women who speak a bit of French, which is a source of social prestige in the capital. Some of them even studied at university. Finally, all of them are members or chairs of associations of traditional healers affiliated with the National Association of Traditional Practitioners of Madagascar (NATPM)[12], which links their therapeutic work to the

[12] Association in charge of identifying and recruiting traditional practitioners in Madagascar, and which consists of several member associations.

political field. Their delivery services cost from 5,000 to 150,000 ariary depending on the patients' social backgrounds, i.e. the capital's middle-class and bourgeoisie. These patients usually go to private clinics in the city but they use the services of these traditional birth attendants because of their good "reputation". Their renown arises from their well-diversified knowledge and practices as traditional practitioners, and from the fact that it is their main activity. As maternal health actors, they emphasise the value of the "gift" passed down from ancestors by whom they were chosen, and who revealed this know-how to them in a dream or through a voice telling them what to do. They also define themselves as descendants of a family of traditional practitioners, psychics or traditional midwives. They state that their "gifts" help them visualise the foetus's position and to reposition it for childbirth without having to use biomedical instruments. Thanks to their gift, they assert that they can also cure sterility, stop haemorrhaging resulting from childbirth, and cure any diseases that are or are not linked to pregnancy. The strong promotion of traditional knowledge and practices by these traditional healers from middle and wealthy social classes is structured around spiritual and primitivist notions which, from a postcolonial perspective, conflict with biomedical, and in a broader sense, Western techniques. As an example, two renowned traditional birth attendants we met claim they do not use *vazaha*[13] supplies, including gloves, for delivery, but only their hands and eyes. The promotion of their knowledge asserts a specific political point of view that improves their reputation and, in turn, their socio-economic prestige.

Conversely, *reninjaza* from lower-income groups in the capital do not emphasise the unusual nature of their skills, although they practice more than traditional birth attendants: as outside the capital and in rural areas, their local recognition is easily built, especially with underprivileged groups. Because of their social background, these *reninjaza* have no ideological standpoint, a low socio-economic status and few demands or expectations in terms of biomedical supplies and resources. They are not involved in the political construction of medical knowledge, in which Western techniques mirror Malagasy magical and religious practices. Yet this postcolonial rhetoric supports the socio-economic status of traditional birth attendants and, in turn, their hierarchical and elitist position compared to *reninjaza*. For example, the traditional birth attendants we met visited training courses offered by the National Institute for Public and Community Health, by the Pharmacology Association of Madagascar, or by the Barefoot Doctors Association to complement their "gift", be vetted by the authorities and be able to work in massage or naturopathy surgeries. Their socio-professional, medical and political status is associated with scholarly knowledge of pharmacopoeia and facilitated by their belonging to the educated social classes. Their recognition overlaps with primitivist ideologies valuing an authentic Malagasy identity, which, in some ways, continue to support national development policies[14].

II. Institutional contradictions and tensions around the status of *reninjaza*

Within the Malagasy Ministry of Public Health, the activities of *reninjaza* fall into two divisions: the Department of Pharmacopoeia and Traditional Medicine (DPTM), since the early

[13] Term that originally referred to "white" Europeans, but now refers to the Western world more generally.

[14] In Madagascar, tourism, environmental resources, homeopathy and natural heritage are economic sectors that combine development dynamics and identity politics.

1990s (it succeeded the Department of Traditional Pharmacopoeia founded in 1986); and the Directorate of Maternal and Child Health and Reproduction (DMCHR). Since they come under the category of traditional healers, *reninjaza* fall within the remit of DPTM, which aims to promote and integrate positive aspects of pharmacopoeia and traditional medicine into healthcare provision. The Department was created with the support of biomedical professionals and scientists to advocate the involvement of *reninjaza* in "safe maternity" by training them and providing them with supplies. DPTM continues to value their practices and knowledge as ancestral skills and expertise. It works with the National Association of Traditional Practitioners of Madagascar (NATPM) and encourages *reninjaza* to become members of one of its affiliated associations. Through DPTM, the medical establishment therefore values the role and status of traditional practitioners and, by extension, the practices of *reninjaza* as any other traditional healers from a clinical and political perspective.

Conversely, professional representatives affiliated with the Directorate of Maternal and Child Health and Reproduction (DMCHR), which also advocates "safe maternity", are opposed to *reninjaza* attending deliveries. They challenge and even reject their activity as traditional healers: *reninjaza* are not deemed to possess the necessary technical skills to provide maternal care. These biomedical professionals see *reninjaza* as unfit to oversee pregnancy, childbirth and the subsequent afterbirth care. DMCHR was one of the bodies advocating the stopping of training courses for *reninjaza* in 2007. Its professionals now recommend that *reninjaza* systematically refer pregnant women to health facilities so that they receive at least four antenatal consultations during pregnancy, and for childbirth. As it is difficult or even impossible to access health facilities in some remote rural areas, it is accepted that *reninjaza* attend the delivery, provided there is no health facility within 5km.
Reninjaza are therefore valued within the medical establishment as traditional healers who carry out "ancestral practices", but also underappreciated with regard to their skills. They face paradoxical lines of questioning that impact their practices. These two contradictory positions within the Ministry of Public Health contribute to the emergence of sociopolitical issues around medical knowledge, with outcomes directly impacting the treatments received by pregnant women in the Malagasy maternal healthcare system. This institutional ambivalence regarding the status and role of *reninjaza* crystallises more than anything the hierarchical relationships between biomedicine and traditional medicine.

Training courses for *reninjaza*, which were originally aimed at combining their practices and knowledge with those of the biomedical system in an attempt to reduce maternal mortality rates, is a concrete example of how they were discredited socially and medically by healthcare professionals. The organisation of these training courses shows, among other things, that the hierarchy between biomedicine and traditional medicine is based on and, in turn, reinforced by class dynamics that differentiate the varying categories of actors in maternal health.
Training courses for *reninjaza*, especially in rural areas, were often organised by UNFPA: they were generally carried out in groups, were very short (never longer than one or two days) and were sometimes remunerated. New biomedical supplies were sometimes handed out, but these were often insufficient to be given out to all participants and swiftly ran out. *Reninjaza* were selected and appointed for these training courses by the doctors of the nearest primary healthcare center. Literacy was one of the requisite conditions, which meant that not all *reninjaza* could take part in these training courses. The selection process thus established a medical and professional hierarchy between health facility personnel and *reninjaza* which was reinforced by socio-

economic inequalities and power relations. As to the input they received during the training courses, it essentially centred on raising awareness and focussed on medical hygiene recommendations and on the importance of referring pregnant women to healthcare centers for antenatal care and delivery. This meant that these training courses fundamentally did not change *reninjaza* practice – save for the fact that they sometimes granted them access to the biomedical supplies they needed – nor the communities' expectations towards them.

Beyond the socioprofessional and medical hierarchy imposed on *reninjaza*, the institutional and political opposition between biomedicine and traditional medicine seems out of line with social and therapeutic realities. For example, although they are classified as traditional healers relating to maternity, the practices of *reninjaza* do not conflict with those of biomedical professionals and do not claim to do so. On the contrary, *reninjaza* wish to integrate the tools and lessons obtained through collaboration with the biomedical system into their body of knowledge. From what they say, institutional representatives of biomedical professionals, on the other hand, tend to devalue the knowledge of *reninjaza* and ignore aspects of their practices that could give better access to healthcare to pregnant women. As we have seen, social ties between them and *reninjaza*, especially in rural areas and more generally in low-income social classes, in which maternal mortality rates are high, are key for antenatal care, childbirth and postnatal care. Yet health workers and their institutional representatives never mention conflicts or difficulties they face in their own relationships with pregnant women, despite the impact these have on the trajectories of their patients, who are then likely to turn to *reninjaza* in their communities.

The ambivalent attitude of the Ministry of Public Health relating to the role and status of *reninjaza* has also led to their occupation being labelled "official", "legal" or "illegal". The institutional organisation implemented to promote traditional medicine did not manage to avoid the development of any form of hierarchy with regard to biomedicine. By becoming members of NATPM, which is widely recommended by DPTM, *reninjaza*, as with all traditional practitioners, have the right to hold a membership card that enables them to practise "legally" and be "protected" if one of their patients dies or faces serious medical problems. The collaboration between DPTM and NATPM to create a register of "real" traditional healers – therefore of "real" and "fake" *reninjaza* – and provide these medical actors with recognition and legitimacy through association membership, results in making non-affiliated *reninjaza* feel "illegal", (especially those practising in the capital). Not being a member of NATPM can be synonymous with illegal practice. Some *reninjaza* therefore become members of an association to appear as "law-abiding" citizens, out of fear of being sent to prison if one of their patients dies during childbirth. However, according to these *reninjaza*, codes and regulations of their associations constrain their occupation. First of all, they have to pay 30,000 ariary in registration fees, followed by an annual association membership fee of 5,000 to 10,000 ariary. They must also comply with the association's rules, which vary depending on the organisation (e.g. compliance with specific medical hygiene measures and professional confidentiality, giving up alcohol and cigarettes, never being found guilty of "misconduct"). These rules impact their practice and do not always take into account their perception and vision of their own role, nor the social ties that connect them to their patients. Some of these ethical codes also promote primitivism to value medical traditionalism in the health arena: a few associations, for example, recommend the avoidance of any medicines or "chemical products", preferring "natural" products only. This primitivism appears to be unique to the institutional and political organisation of traditional therapeutics in the capital and reflects class dynamics that conflict with the practices and perceptions of

reninjaza from low-income and underprivileged social classes. The only advantage they derive from their membership with an association is the "legalisation" of their status in the eyes of the State: willingly or not, they apply a certain political and professional rationale to their activity.
Outside the capital, in rural and urban areas, their status is under less pressure and strain from the State and NATPM. Only one of the surveyed *reninjaza* had heard of NATPM, since it had been mentioned by a traditional practitioner she had consulted for her own child. But she did not know what benefits she could expect from being a member of such a medical association. On the other hand, *reninjaza* who refer pregnant women to healthcare centers are given a more favourable introduction by professionals in the biomedical care system: they are presented as "legal" or "official".
However, despite institutional and political processes establishing hierarchies between biomedicine and traditional medicine, instances of overlap and collaboration between these mirroring fields of medical knowledge are inevitable within maternal health facilities.

III. Ambiguities and realities in maternal healthcare provision

Professional and political discourse that distinguishes, opposes, excludes and establishes hierarchies between biomedical and traditional practices and knowledge does not hold up to therapeutic realities. An interview with a representative of Malagasy reproductive health professionals, conducted in a district health unit in the region Antananarivo, shows the discrepancies between Ministry of Public Health guidelines issued by DMCHR on the role of *reninjaza* and practical needs in maternal healthcare provision for pregnant women:

> "According to national policies here in Madagascar, *reninjaza* are no longer allowed to receive and attend delivery of women. They have to refer them to healthcare centers. (…) The Ministry of Public Health no longer accepts the attendance of *reninjaza* at deliveries. (…) Before I took up this post, it was permitted. However, this has not been the case for 7 years now because we have not reached our Millennium Development Goals, and because of maternal deaths occurring outside health facilities during childbirths and attended to by *reninjaza*. (…) But [primary healthcare center personnel] organise meetings because we cannot downplay the role of *reninjaza*, as health workers cannot cope with the workload by themselves. And there are always women who go to *reninjaza* to give birth and ask them for advice. So on the one hand, in the Ministry's view, *reninjaza* are no longer allowed to attend deliveries, but on the other hand, they still practice, so the heads of primary healthcare centers are charged with retraining *reninjaza*. (…) It's better to work together than ban them altogether, because that would cause harm. It's better to raise awareness among *reninjaza* and to retrain them periodically."

Health workers try to adapt their practices to daily situations, socio-economic background, and their own capacities to provide care to parturient women, as well as to their perception of the *reninjaza* with whom they can collaborate. In rural areas, for example, many women have no other option than to give birth on their own or seek assistance from a *reninjaza*. Primary healthcare center personnel must deal with this social reality. At different levels of maternal healthcare provision during pregnancy, various forms of collaboration around *reninjaza* practices and knowledge emerge, despite recurring contradictions with regard to their status and role.

Administratively, health authorities, such as district health units or village authorities, list *reninjaza*, require them to provide records of childbirths they attend to and to fill in a register to draw up acts of birth. Some *reninjaza* keep notebooks that they hand over to the *fokontany* president of their community to perform these administrative formalities (in cases where *reninjaza* are not literate, the *fokontany* president fills out the register on their behalf). They also take care of registering births at the town hall, even in the capital. Due to the fact that the last national census dates back to 1993, births and deaths are difficult to monitor (especially in low-income and underprivileged classes in urban and rural areas), and because the patronymic does not automatically establish genealogy in a lot of families, *reninjaza* appear to be key resource persons.

From a medical viewpoint, collaboration between health workers and *reninjaza* takes different forms in urban and rural areas. In Antananarivo, for example, instances of collaboration are few and far between according to the Institut Pasteur in Madagascar, even if complications do occur during childbirth. There are no "handover forms" to ensure communication between healthcare centers and *reninjaza*. Those who are not members of NATPM are deemed to be practising illegally. As for traditional birth attendants, although they are recognised by political institutions, associations and some members of Antananarivo's upper-class families, their practices are not combined with those of hospital and healthcare center personnel.
On the other hand, in rural areas, most primary healthcare center professionals stated in the survey that they cannot attend all deliveries due to a lack of personnel, time, resources and space. They acknowledge that *reninjaza* play a key role in their own practices, although they lack the necessary medical training or skills. These health workers value several models of collaboration with the *reninjaza* they chose to work with, either because they have basic training or because they comply with some medical hygiene standards. Unlike in other Southern countries, the training courses that used to be offered to *reninjaza* are given little weight when establishing such collaborations. But these happen to be easier when *reninjaza* consider themselves at the lower end of a social and professional hierarchy that includes healthcare center personnel.

Collaboration can take various forms and is always initiated by primary healthcare center professionals with the approval or at the request of the local authorities. It can be structured around the accompaniment of pregnant women by *reninjaza* for antenatal consultations and during delivery, in line with DMCHR recommendations. When involved in care provision around childbirth, the role of *reninjaza* is limited to accompanying the patient: they are not tasked with any medical procedures. They are rather seen as a family member who has come to support the pregnant or parturient woman. Although this type of collaboration with *reninjaza* does not imply any therapeutic practice, it is considered necessary by authorities and health workers to improve maternal healthcare. According to this vision, the know-how of *reninjaza* is also considerably discredited: their practices during childbirth are deemed dangerous, inappropriate and too far removed from requisite medical and technical knowledge. For example, *reninjaza* are accused of waiting too long before delivery, hindering any possible identification of complications and timely referral of parturient women to primary healthcare centers. The remedies they use, such as herbal teas, as well as their failure to comply with some medical hygiene standards, are also seen as sources of infection. These points provide yet another argument for holding *reninjaza* involvement responsible for the sustained high rates of maternal mortality.

A second form of collaboration consists in giving *reninjaza* who often refer parturient women to primary healthcare centers a role of assistants or helpers. Health workers are grateful for some of their abilities, such as monitoring the perineum or washing the newborn baby, especially if they are busy attending to other patients. Some are happy to be able to supervise and control what *reninjaza* do to teach them "good practice". Once they have acquired the relevant techniques, they are sometimes delegated tasks. However, despite participative collaboration, primary healthcare center personnel still assert their authority over *reninjaza* and use control and pedagogy to uphold their medical legitimacy. Moreover, when health workers mention these forms of cooperation, they do not highlight their professional interest in the training of *reninjaza* or in women and newborn care, but more personal expectations, such as the opportunity to receive support, to leave the primary healthcare centers for some time, and to delegate childbirth. In this context, too, the role of the *reninjaza* is considered inferior to biomedical science. Once again, this hierarchy is based on class distinction and on the actors' positions on the social ladder. It must be stressed here that most *reninjaza* are farmers, something that accentuates their inferiorization by primary healthcare centers personnel.

In the Malagasy maternal healthcare system, combining the know-how of *reninjaza* with health workers' practices challenges power dynamics in the medical arena and, as in other countries, makes for weak and porous boundaries between biomedicine and traditional medicine (Longuenesse, 1995; Benoist, 1996). Patients' health trajectories also build bridges between *reninjaza* and biomedical professionals (Akoto et al., 2001). Many women decide to turn to a health facility during their pregnancy to access antenatal consultations and make sure they will receive treatment in the event of complications during childbirth. This practice is becoming a social norm. Likewise, some *reninjaza* ask women to have at least one consultation in a healthcare center, which maintains their collaboration with facility personnel. Finally, some midwives even ask their patients to consult *reninjaza* for massages to reposition the foetus before childbirth. Health workers do not see practices of *reninjaza* as scholarly or scientific, but some concede that they have a "gift". Coupled with a form of spirituality related to primitivism, these "gifts" are deemed to guarantee the effectiveness and success of some of the medical care that health workers cannot offer (such as turning the foetus if it is in the wrong position before childbirth). As we can see, although they are considered inferior to biomedical science, some therapeutic practices carried out by *reninjaza* are sometimes recommended, i.e. in cases where biomedical professionals are powerless. In this situation, care and treatments are "Malagasised", to use a common expression. This leads to a strongly ethnicised promotion of local medical traditionalism, and, in practice, to erasing boundaries between two therapeutic fields that are essentialised in mirroring positions.

Conclusion

In Madagascar, national and international health policies promoted the association of, and subsequently established hierarchies between, knowledge and practices from biomedicine on the one hand and traditional medicine on the other. Both processes aimed to improve maternal healthcare and reduce mortality rates during childbirth. However, neither of the two approaches has led to the desired outcomes, as they do not take into account the distinctions established between the various categories of medical actors. In practice, the socio-economic realities faced by pregnant women take precedence over political issues about the definition and

institutionalisation of medical knowledge related to maternity. Health actors, on the other hand, seem to abstain from a certain reflexivity that would prioritise their patients' needs.

Pregnant women from low-income and underprivileged social classes in rural and urban areas widely choose to consult *reninjaza*, as the services they offer are cheap or even free. However, some women consulting *reninjaza* fear that there will be complications during labour and delivery, that they will be referred too late to a healthcare center or that they will have to undergo risky and potentially fatal emergency surgery. Some pregnant women therefore decide to save up to make sure they receive antenatal care from a healthcare facility or turn to midwives who attend home births. *Reninjaza* are fully aware of the limitations of their own knowledge, especially with regard to possible complications during childbirth. However, none of the *reninjaza*, or traditional practitioners fulfilling a similar function we met, mentioned any deaths of women during childbirth. This is surprising in light of the fact that maternal mortality rates lead to believe that many *reninjaza* would have witnessed the death of a patient at least once in their career. What they mentioned instead were deaths of newborn babies, fatalities that are treated as commonplace by women as much as by *reninjaza*. Their attitudes and perceptions of the realities of maternal and infant mortality therefore reinforce the derogatory discourse of biomedical practitioners towards them.

On the other hand, biomedical professionals never mention the difficulties they face with pregnant women, nor their perceptions of healthcare centers, or the conflicting and violent patient-carer relationships that emerge within these same facilities (Mestre, 2014). Yet they reinforce power dynamics based on socio-economic inequalities and on the classic asymmetry between patients and holders of medical knowledge. These aspects, which often complicate patient healthcare, are often overlooked by analyses of health workers' practices in health facilities (Jaffré & Olivier de Sardan, 2003). Biomedical professionals tend to attribute deaths during childbirth to harmful practices by *reninjaza*, to the lack of (financial, materiel and human) resources in health facilities, and to many women's early and frequent pregnancies. However, even in the middle and privileged classes in urban areas, especially in the capital, some pregnant women turn to *reninjaza*, even though their social and geographical backgrounds are very different from those of women from low-income, underprivileged and rural classes. What these women have in common is their misgivings regarding how they will be received by health workers, the attitudes of some biomedical practitioners who are neither attentive to their needs, nor competent or even present, and regarding unnecessary surgery.

Maternal health in Madagascar would certainly benefit from reflection and changes based on patients' perceptions, experiences and practices, as well as on their trajectories within the healthcare system. For the essentialised, simplistic and stigmatising distinction – that tends to divide medical knowledge between traditionalism on the one hand and "modernity" on the other – fuels power issues that prevent from gaining a full understanding of the social realities at stake.

References

Akoto, E. M., Songue, P. B., Lamlenn, S., Kémajou, J. P. W., Gruénais, M-E. (2001). « Infirmiers privés, tradipraticiens, accoucheuses traditionnelles à la campagne et à la ville », *Bulletin de l'APAD*, 21. Mis en ligne le 10 avril 2006. URL : http://apad.revues.org/101.

Amselle, J-L. (2010). *Rétrovolutions. Essais sur les primitivismes contemporains*. Paris : Stock.

Amselle, J-L. (2012). « Au nom des peuples : primitivismes et postcolonialismes ». *Critique*, 776–777 (1–2). 165-177.

Benoist, J. (dir.) (1996). *Soigner au pluriel. Essais sur le pluralisme médical*. Paris : Karthala.

Boyer, V. (2006). « Le mouvement des sages-femmes traditionnelles dans l'Amapá : Une mobilisation féminine exemplaire et les limites du développement local. », *Nuevo Mundo Mundos Nuevos*, mis en ligne le 17 mars 2006. URL : http://nuevomundo.revues.org/1965.

Cortadellas D., Andriantsiferana M., Laboute P., Razanamparany L. (2010). « Les substances naturelles d'intérêt pharmacologique ». In Feller, C. & Sandron, F. *Parcours de recherche à Madagascar*. Marseille : Editions IRD.

Debray, M. (1975). « Médecine et pharmacopée traditionnelles à Madagascar ». *Etudes Médicales*, 1, 69-85.

Didier, P. (2012). « Les médecines traditionnelles entre politiques locales et décisions internationales : le cas de Madagascar », *Sociologie Santé*, 36, 171-192.

Dozon, J-P. (1987). « Ce que valoriser la médecine traditionnelle veut dire ». In Politiques de santé, *Politique africaine*, 28, 9-20.

Fassin, D. (1992). *Pouvoir et maladie en Afrique*. Paris : Presses universitaires de France.

Fournier, P. & Perrault V. (2013). « Le rôle des relais communautaires et des accoucheuses traditionnelles durant la période périnatale dans la région de Kayes au Mali ». In Fournier, P., Haddad, S., Ridde, V. (dir). *Santé maternelle et accès aux soins en Afrique de l'ouest*. Paris : L'Harmattan.

Hancart-Petitet, P. (2013). « Les derniers jours de Palavankodie. Transformations et effacement des pratiques des matrones en inde méridionale ». In Pordié, L. & Simon, E. *Les nouveaux guérisseurs. Biographies de thérapeutes au temps de la globalisation*. (p. 99-113) Paris : EHESS.

Hancart Petitet, P. (dir). (2011). *L'art des matrones revisité. Naissances contemporaines en question*. Paris : Editions Faustroll Descartes.

Institut National de la Statistique (INSTAT) & ICF Macro. (2010). *Enquête Démographique et de Santé-Madagascar, 2008-2009*. Antananarivo, Madagascar.

Jaffré, Y. & Olivier de Sardan, J-P. (2003). *Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans cinq capitales d'Afrique de l'ouest.* Paris : APAD, Karthala.

Jordan, B. (1993). *Birth in Four Cultures. A crosscultural investigation of childbirth in Yucatan, Holland, Sweden and the United-States*. Prospect Heights: Waveland Press. First Published in 1978

Lefèvre, G. (2008). « Les discours sur la médecine traditionnelle à Madagascar. Entre idéologie coloniale, salut de l'âme, raison économique et pouvoir biomédical », *Revue des Sciences Sociales*, 39, 46-59.

Longuenesse, E. (dir.). (1995). *Santé, Médecine et Société dans le monde arabe*. Paris : L'Harmattan / Lyon : Maison de l'Orient Méditerranéen.

Mestre, C. (2014). *Maladies et violences ordinaires dans un hôpital malgache*. Paris : L'Harmattan.

Olivier de Sardan, J-P. (1995). *Anthropologie du développement : essai en socio-anthropologie du développement social*. Paris : Karthala.

OMS. (2013). *Statistiques sanitaires mondiales*. Genève : Organisation mondiale de la Santé.

Pordié, L. & Simon, E. (2013). « Que sont les guérisseurs devenus ? Le monde des soins à l'heure de la globalisation ». In *Les nouveaux guérisseurs. Biographies de thérapeutes au temps de la globalisation*. Paris : EHESS.

Pourchez, L. (2011). *Savoir des femmes : médecine traditionnelle et nature – Maurice, Réunion, Rodrigues*. Savoirs locaux et autochtones, 1. Paris : Organisation des Nations-Unies pour l'éducation, la science et la culture.

Pourette D., Mattern C. et Raboanary E. (2013). Etude qualitative MEDALI-Mission d'Etudes des Déterminants de l'Accès aux Méthodes de Lutte antipaludique et de leur Impact, Rapport de recherche, Antananarivo, CEPED-IPM-UCM-Le Fonds Mondial-FEI-MAE.

Rakotomalala, M. (2002). « Transformations du politique et pluralité thérapeutique », *Journal des anthropologues*, 88-89, 41-52.

Rakotomalala, M. (2012). A cœur ouvert sur la sexualité Merina (Madagascar). Une anthropologie du non-dit. Paris : Karthala.

Ramanantenasoa, B. P. (1996). Méthodes de diagnostic et traitements des maladies par les plantes médicinales chez un guérisseur dans le fokontany d'Antanetibe Ambohitrimanjaka , Thèse de doctorat en médecine, Université d'Antananarivo.

Ravololomanga, B. (1993). *Etre femme et mère à Madagascar*. Paris : L'Harmattan.